Family Directed Services Program Update Notification

Past publications of the *FDS Program Update Notification* are stored on the FDS DHW website.

What's New in Paperwork?

Updates to Support and Spending Plan:

The Centers for Medicare and Medicaid Services (CMS) published new regulations in 2014 that implemented requirements for state Medicaid Home and Community Based Settings (HCBS) programs. In response to the CMS regulations, Idaho promulgated HCBS rules which align with the HCBS which align with the HCBS requirements. These became effective July 1, 2016 and can be found in IDAPA 16.03.10.310.

A summary of the updates and additions are below:

1. Support Brokers will note if the child was invited to the FCP meeting (Cover Page)
2. If the child does not attend the FCP meeting, document why. (Cover Page)
3. The Fiscal Employer Agent is required to sign after SSP is authorized. (Cover Page)
4. Added acknowledgement statement to FEA and SB signature. (Cover Page)
5. A new page was added to document Needs, Strengths, Preferences, Locations, and Goals listed in the workbook. (page 3)
6. FEA fee is no longer filled in. SB will need to complete the FEA monthly fee in FEA Annual Authorization section. FEA name is added. (FEA Authorization)
7. Choice and Informed Consent Statement modified to add HCBS language.

This new form must be implemented by June 1st, 2017 but can be used prior to this date.

Have Questions??

Join us on a conference call May 9th, 2017 at 12:00pm for a review of the SSP updates. We will review the additions/changes and answer questions on completing this revised document. Call: 1-877-820-7831 with the code 783110.

Updating the Workbook

If a new service is requested through a Plan Change, and the need for the service is not documented in the Workbook, the Case Coordinator will require an update to the Workbook. The entire Workbook can be resubmitted or simply the updated sections.

Support Brokers Needed

According to data from 2016, 95 languages are spoken in Idaho! Bilingual Support Brokers are needed!

Recommendations for recruitment opportunities for potential bilingual Support Brokers are welcome! Contact Rachel Johnson at Rachel.Johnson2@dhw.idaho.gov or 208-334-0603.

FAMILY AND COMMUNITY SERVICES

Family-Directed Services Program

www.familydirected.dhw.idaho.gov

Inside this issue:

FAMILY-DIRECTED SERVICES
Support and Spending Plan

version: 4/11/2017

IDAHO DEPARTMENT OF
HEALTH & WELFARE

CHILD'S NAME: MID#: DATE:

SUPPORT AND SPENDING PLAN COVER SHEET

SSP must be completed in detail, leaving no blank spaces. If not applicable, please, indicate so with "n/a"

☐ Initial Plan ☐ Annual Plan Diagnosis:

PERSONAL INFORMATION

Community Living Arrangement:	Date of Birth:		Gender:
Address:	City:	State:	Zip Code:
Telephone Number(s): Home: ( )	Cellular: ( )	Other: ( )	
Parent(s) Name:		Email:	
May the FDS program contact you and send you copies of material via this email address? ☒ Yes ☐ No			
Address:	City:	State:	Zip Code:
Telephone Number(s): Home: ( )	Cellular: ( )	Other: ( )	
Legal Guardian (if not Parent) Name:		Email:	
May the FDS program contact you and send you copies of material via this email address? ☐ Yes ☐ No			
Address:	City:	State:	Zip Code:
Telephone Number(s): Home: ( )	Cellular: ( )	Other: ( )	
Primary Care Provider:	Phone: ( )	Fax Number: ( )	

Was the child invited to the FCP Meeting? ☐ Yes ☐ No Did the child attend the FCP meeting? ☐ Yes ☐ No
If no, list parent/legal guardian's reason why:

PEOPLE WHO HELPED CREATE THIS PLAN

Printed Name: Signature:	Parent or Legal Guardian (pls. circle)
Printed Name: Signature:	Parent or Legal Guardian (pls. circle)
Printed Name: Signature:	Relationship to Child:
Printed Name: Signature:	Relationship to Child:
Qualified Fiscal Employer Agent: Signature:	Fiscal Employer Agent (FEA): By signing I agree that this plan will be implemented following HCBS requirements and payments will be delivered according to the authorized plan.
Printed Name: Phone(s): ( ) Signature:	Qualified Support Broker/ Plan Developer By signing I agree that this Plan was developed to meet HCBS requirements and services will be delivered according to the authorized plan.

CHILD'S NAME: MID#: DATE:

PLANNING INFORMATION

Please list the needs of the child that were identified on the Workbook.
1.
2.
3.
4.
5.
6.

Please list the child's strengths identified on the Workbook.
1.
2.
3.
4.
5.
6.

Please list the child's preferences identified on the Workbook.
1.
2.
3.
4.
5.
6.

Please list the locations and settings where services will be implemented.
1.
2.
3.
4.
5.
6.

What is the ultimate goal for your child?

CHILD'S NAME: MID#: DATE:

ANNUAL SUPPORT PLAN

Goal:
Desired Outcome:

Activities What activities can my child currently do themselves to reach goal or meet need?	**How Often?**

Natural Supports Who could help my child reach goal or meet need that wouldn't have to be paid?	**How Often?**

Medicaid Paid Supports Service, Task, or Good Needed this Plan Year	**Type of Support**
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
Steps to Independence: What can be done to develop more independence?	

CHILD'S NAME: MID#: DATE:

ANNUAL SUPPORT PLAN

Goal:
Desired Outcome:

Activities What activities can my child currently do themselves to reach goal or meet need?	**How Often?**

Natural Supports Who could help my child reach goal or meet need that wouldn't have to be paid?	**How Often?**

Medicaid Paid Supports Service, Task, or Good Needed this Plan Year	**Type of Support**
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
Steps to Independence: What can be done to develop more independence?	

CHILD'S NAME: MID#: DATE:

ANNUAL SUPPORT PLAN

Goal:
Desired Outcome:

Activities What activities can my child currently do themselves to reach goal or meet need?	**How Often?**

Natural Supports Who could help my child reach goal or meet need that wouldn't have to be paid?	**How Often?**

Medicaid Paid Supports Service, Task, or Good Needed this Plan Year	**Type of Support**
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
Steps to Independence: What can be done to develop more independence?	

CHILD'S NAME: MID#: DATE:

ANNUAL SUPPORT PLAN

Goal:
Desired Outcome:

Activities What activities can my child currently do themselves to reach goal or meet need?	**How Often?**

Natural Supports Who could help my child reach goal or meet need that wouldn't have to be paid?	**How Often?**

Medicaid Paid Supports Service, Task, or Good Needed this Plan Year	**Type of Support**
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
Steps to Independence: What can be done to develop more independence?	

CHILD'S NAME: MID#: DATE:

ANNUAL SUPPORT PLAN

Goal:
Desired Outcome:

Activities What activities can my child currently do themselves to reach goal or meet need?	**How Often?**

Natural Supports Who could help my child reach goal or meet need that wouldn't have to be paid?	**How Often?**

Medicaid Paid Supports Service, Task, or Good Needed this Plan Year	**Type of Support**
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.
Steps to Independence: What can be done to develop more independence?	

OTHER SUPPORTS AND SERVICES

Private Clinic Therapy Services (PT, OT, SLP, psychology)	How Often?

Services in the school (skill building or behavioral)	How Often?
School Attending:	
Is child currently on IEP: ☐ Yes ☐ No	

Medical Services and Clinics	How Often?
Specialist(s):	

Miscellaneous (transportation, etc.)	How Often?

BACK-UP PLAN

If problem or at-risk behaviors were identified in the *Workbook* that jeopardize the health or safety of the child or others, or if there are other health and safety issues that others need to know of while supervising the child to ensure the child's safety, a back-up plan must be developed for that support to direct the CSW supervising the child.

A back-up plan is an action plan. For any risk identified that requires a back-up plan, first list the overall support that needs to be provided followed by three (3) prioritized mean to provide that support. Please enter this information in the spaces provided below. A list of phone numbers to contact if a situation arises in not an adequate back-up plan.

Risk Identified:
Support that needs to be provided:
Back-Up Plan: 1. 2. 3.
Risk Identified:
Support that needs to be provided:
Back-Up Plan: 1. 2. 3.
Risk Identified:
Support that needs to be provided:
Back-Up Plan: 1. 2. 3.

CHILD'S NAME: MID#: DATE:

ANNUAL SUPPORT AND SPENDING PLAN AUTHORIZATION

Service, Task, or Good this Plan Year	Name of Person, Agency, or Vendor Providing the Support	Hours/ Items Needed Per Year		Cost Per Hour/ Item With Taxes		Annual Cost
Personal Support: To maintain health, safety and basic quality of life.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
Emotional Support: To learn and practice behaviors consistent with goals while minimizing interfering behaviors.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
Learning Support: To learn new skills or improve existing skills that relate to identified goals.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
Relationship Support: To establish and maintain positive relationships with immediate family members, friends, or others in order to build a natural support network and community.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
		PAGE 1 TOTAL: $				

CHILD'S NAME: MID#: DATE:

Service, Task, or Good this Plan Year	Name of Person, Agency, or Vendor Providing the Support	Hours/ Items Needed Per Year		Cost Per Hour/ Item With Taxes		Annual Cost
Adaptive Equipment: Equipment that meets a medical or accessibility need and promotes increased independence.						
			x		=	
			x		=	
			x		=	
			x			
				Total = $		
Transportation Support: To accomplish identified goals through gaining access to community services, activities, and resources.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
Job Support: To provide support to secure and maintain employment or attain job advancement.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
Skilled Nursing Support: Intermittent or private duty nursing services within the scope of the Nurse Practice Act provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.						
			x		=	
Qualifications required to provide needed support.						
			x		=	
Qualifications required to provide needed support.						
				Total = $		
		TOTAL PAGE 1: $				
		TOTAL PAGE 2: $				
TOTAL PAGE 1 + TOTAL PAGE 2 = TOTAL ANNUAL SUPPORTS AND SERVICES: $ ___ (A)						

All providers, including CSWs, must be given a copy of the Support and Spending Plan.

SUPPORT BROKER AUTHORIZATION

REQUIRED JOB DUTIES THIS PLAN YEAR	Hours Per Year		Cost Per Hour		Annual Cost
Participate in the family-centered planning process.		x		=	
Develop a written Support and Spending Plan, including the development of 3 back-up plans for every identified risk.		x		=	
Assist the parent to monitor and review the budget.		x		=	
Submit documentation to the Department, as requested, regarding satisfaction with services.		x		=	
Participate in Department Quality Assurance measures, as requested.		x		=	
Assist the parent to complete annual re-determination process as needed.		x		=	
Assist the parent to complete the responsibilities of the programs and meet the child's health and safety needs.		x		=	
Complete the Department approved Criminal History Check Waiver Form for CSWs as requested by the parent and provide counseling to the parent regarding the risks of waiving the Criminal History and Background Check.		x		=	
REQUIRED JOB DUTIES SUBTOTAL $ ___					
OTHER REQUESTED JOB DUTIES	**Hours Per Year**		**Cost Per Hour**		**Annual Cost**
		x		=	
		x		=	
		x		=	
		x		=	
		x		=	
OTHER REQUESTED JOB DUTIES SUBTOTAL $ ___					
REQUIRED JOB DUTIES + OTHER REQUESTED JOB DUTIES = SUPPORT BROKER TOTAL $ ___ (B)					

CHILD'S NAME: MID#: DATE:

FISCAL EMPLOYER AGENT ANNUAL AUTHORIZATION

Fiscal Employer Agent Name:	
Number of months in which FEA will complete Payroll transactions	
Number of months in which FEA will pay for Goods	
Total Number of months FEA services will be used	
$ x (months)	
TOTAL FEA FEES FOR THIS PLAN YEAR	**$ ___ (C)**

ANNUAL PLAN AUTHORIZATION SUMMARY

SUPPORTS AND SERVICES TOTAL FOR THIS PLAN YEAR (A) $___

SUPPORT BROKER TOTAL FOR THIS PLAN YEAR (B) $___

FISCAL EMPLOYER AGENT TOTAL FOR THIS PLAN YEAR (C) $___

ANNUAL PLAN YEAR GRAND TOTAL $___

NO SERVICES OR GOODS CAN BE SPENT UNTIL THE SSP HAS BEEN AUTHORIZED BY THE CASE COORDINATOR REGARDLESS OF THE ANNUAL PLAN DATES.

TO BE COMPLETED BY FACS CASE COORDINATOR

ANNUAL PLAN DATES: FROM _____ TO _____

PLAN AUTHORIZED BY: _____ ON _____
FACS CASE COORDINATOR DATE

ASSESSED ANNUAL MEDICAID BUDGET: $_____

APPROVED REQUEST ANNUAL AMOUNT: $ _____

REMAINING DIFFERENCE: $ _____

Alphabetically by Child's Last Name	Case Coordinator Contact Information		
A - D	Jennifer Funk (North ID)	Jennifer.Funk@dhw.idaho.gov	(208) 798-4118
E - K	Lynda Bales (East ID)	Lynda.Bales@dhw.idaho.gov	(208) 234-7978
L - R	Noralee Fitch (Southwest ID)	Noralee.Fitch@dhw.idaho.gov	(208) 475-5091
S - Z	Laura Banks (Southwest ID)	Laura.Banks@dhw.idaho.gov	(208) 475-5094

CHILD'S NAME: MID#: DATE:

CHOICE AND INFORMED CONSENT STATEMENT

Instructions: Read, sign, and date the *Choice and Informed Consent Statements* below.

I have reviewed the services contained in this Support and Spending Plan, choose to accept this plan, and understand my responsibilities under the Family-Directed Services option.

By signing this page, I acknowledge that as the parent or legal guardian of this child, I have assisted in developing my child's Plan and made decisions regarding the type, amount and frequency of services. I agree that services will be delivered according to the provisions outlined in this Plan. It is my responsibility to assure that services do not exceed the parameters and cost that is identified in this Plan and are consistent with Home and Community Based Services requirements. If modifications are necessary to type, amount, or frequency of service, I will contact my Support Broker to complete a Plan Change in order to obtain authorization for the changes.

I also understand and acknowledge by signing below, that this Plan and the annual budget, on which it is based, include community developmental disabilities services which are intended to cover a one year time period.

_____ _____

Parent or Legal Guardian Signature Date

Complete if funded by the DD Waiver

Informed Consent Statement for Family-Directed Community Services Option:

I have been informed of and understand my choice of waiver services. I choose to receive Family - Directed Community Supports, rather than to accept placement for my child (or ward) in an Intermediate Care Facility for the Intellectually Disabled. I understand that I may, at any time, choose facility admission for my child.

_____ _____

Parent or Legal Guardian Signature Date

If you are not using your child's budget in less than 12 months, the paragraph below does not apply.

I am choosing to use all my child's annual budget in a shortened time period (less than 12 months) within this plan year. By using my child's budget this way, I understand that he/she will not have any remaining budget for children's DD services for the remainder of the year. I agree that using the budget in this way meets my child's needs. The following supports will be in place to assure their needs can be met without community based services during this time:

_____ _____

Parent or Legal Guardian Signature Date